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When East Meets West to Address Shame and Treat Insecure Attachment

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Abstract

When East Meets West to Address Shame and Treat Insecure Attachment

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Attachment theory provides evidence that infants and children who perceive insufficient care and attunement tend to develop emotional, social, and behavioral deficits (Bowlby, 1969, 1973, 1988; Ainsworth, 1989). The hidden root that sustains attachment-based symptoms and syndromes is shame. Shame is defined as an injury to the self as a result of contemptuous or humiliating treatment from a valued person (Erskine, 1994; Evans, 1994). Similarly, Bowlby (1988) posits that shame is an adaptive, biological response when a child see's their caretaker as unavailable or hurtful. Children attempt to rationalize their painful emotional experiences, but because they are driven to seek and maintain attachment bonds with caregiving figures, they often disavow anger toward such figures and surmise they are bad, unworthy, or incapable of love. This system of thinking and the associated psychopathology can maintain through adulthood (Bartholomew & Horowitz, 1991; Shaver & Mikulincer, 2007; Wei et al., 2011). While attachment-based symptoms like depression, anxiety, and anger are typically treated in the West from a medical model perspective, shame often endures and keeps clients stuck in insecure

attachment styles. On the other hand, Eastern-based therapeutic treatments that incorporate mindfulness and self-compassion uniquely and effectively quell shame (Gilbert & Procter, 2006; Leary, Adams, & Tate, 2006; Luoma et al., 2012). As such, this report advances that these ancient methodologies may be better suited for adult clients with insecure attachment concerns.

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CHAPTER 1

Introduction

Western approaches to psychotherapy have traditionally been driven by a medical model in which the goal is diagnosis and treatment of symptoms. This is also true for individuals with insecure attachment issues who may experience syndromes and symptoms such as depression and anxiety, but also endure problems that pervade the sense of self and relationships in a way that is not limited to specific symptoms. Notably, shame has been verified as a frequent concomitant of attachment difficulties, and may be a vehicle that sustains mental health problems for those with insecure attachment. Unlike illnesses and diagnoses that can be remedied with a prescription or formulaic therapy, individuals with pervasive attachment difficulties may benefit from a treatment approach that contrasts the standard Western mindset. Insecure attachment is a significant issue that effects self-identities, emotional regulation, interpersonal relationships, and health behaviors. Eastern-based therapeutic approaches may uniquely and effectively reduce the shame that encumbers attachment security.

Attachment theory has long shown that infants and children who've perceived insufficient attunement from their primary caregivers can go onto display maladaptive behaviors (Simpson, Rholes, & Phillips, 1996) and psychological distress (Davila & Bradbury, 2001), including anxiety (Shaver & Mikulincer, 2002, 2007), depression (Feeney et al., 2003; Wei, Shaffer, Young & Zakalik 2005), substance use/misuse (Brady & Sonne, 1999; Cook, 1991), and difficulties with bereavement (Schenck, Eberle & Rings, 2016), sleeping, (Hall et al, 2000; Sloan, Maunder, Hunter & Moldofsky, 2007) and interpersonal relationships (Davila, Karney & Bradbury, 1999; Saavedra, Chapman, & Rogge, 2010). The root of these problems can extend past infancy and maintain through adulthood (Thompson & Raikes, 2003). Some of the latest research on the topic illustrates

that an estimated 44% of Americans are believed to have one of the three types of insecure attachment styles defined by Bowlby (Hazan & Shaver, 1987; Mickelson, Kessler, & Shaver, 1997). This is a staggering percentage of the population that is befitting of mental health services even though it does not include the more stereotypical instigators of therapy like trauma or life transitions.

To mitigate attachment issues and other mental health concerns, Western medicine and much of psychology has operated with a symptom abatement approach. In the West, the culture promotes quick fixes and exhibits an intolerance for pain, suffering, and vulnerability. This can be seen in the way mental health is addressed by professionals as well as clients. From self-medication and psychotropic treatment to short-term behavioral therapy, clients and maxed-out counseling centers are more commonly relying on modalities that will show immediate results (Kay, 2010). A survey from the National Survey of Directors recently reported that 93% of college counseling center directors have seen an increased number of student-clients on antidepressants and other psychotropic medications. At the same time, the survey reported about a third (33.5%) of clients terminate counseling prematurely (Kay, 2010). When therapy is available and considered, results-driven treatment modalities like Cognitive Behavioral Therapy (CBT) are often preferred because they provide relatively short treatment and are empirically validated to be as effective, if not more effective than psychotropics (Bannink, 2007; Flynn, 2011; Jackson, O'Malley, & Kroenke, 2006). The reality of Western care is that even mental health needs are often pacified with quick remedies and medically based treatments.

On the other hand, therapeutic modalities that incorporate Eastern philosophical principles take a different approach to client suffering. Rather than changing thoughts or behaviors, or relying on psychotropic medication to alleviate symptoms, Eastern counseling practices encourage "holding" thoughts with mindfulness and compassion, and

increasing one's tolerance for painful emotions (Hayes, 2004; Roemer, Williston, Eustis, & Orsillo, 2013). In fact, a growing body of research on mindfulness and self-compassion provides ample justification for its incorporation into mental health treatment plans when clients demonstrate attachment disorders; research studies have demonstrated that when people with insecure attachment practice mindfulness and self-compassion, they show less distress than those who do not utilize such Eastern principles (Saavedra, Chapman, & Rogge, 2010; Shaver, Lavy, Saron, & Mikulincer, 2007; Snyder, Shapiro, & Treleaven, 2012; Wei, Yu-Hsin Liao, Ku, & Shaffer, 2011).

Not only does research posit the utility of an Eastern philosophical mindset for attachment concerns, it suggests there is a key component of attachment insecurity that benefits from mindfulness and self-compassion, and that is shame (Gilbert & Procter, 2006; Lee, 2005; Luoma, Kohlenberg, Hayes, & Fletcher, 2012). Often clients do not identify themselves as people with attachment disorders, they seek therapy because of psychological symptoms associated with entrenched shame and discomfort with their vulnerabilities, which often stems from their families of origin. Mindfulness and self-compassion can help alleviate their symptoms because it attacks shame and bolsters feelings of acceptance and forbearance. Given the evidence that shame frequently accompanies insecure attachment and that it may play an important role in perpetuating dysfunction, this report aims to advance the idea that mindfulness and self-compassion promoting interventions may be especially useful in treating clients with insecure attachment.

CHAPTER 2

Literature Review of the Effects of Insecure Attachment

Attachment

Attachment theory was conceptualized by John Bowlby in the 1950's with the intention to better understand the relationships between infants and mothers/caregivers (Bowlby, 1969; Ainsworth, 1989). The theory provides justification for why infants typically display tendencies towards their primary caregivers, rather than just any adult, for emotional bonding and getting their physical needs met. Attachment theory also explains the impact of parent-child relationships. Bowlby (1969) posits that humans are born with an intrinsic motivation to seek care and safety from proximal human sources, and that the quality of relationships with caregivers influences how children develop socially and emotionally. In the first year of life, infants gradually build expectations about how their caregivers will respond to them. For example, if a child cries when she is uncomfortable and the mother consistently sooths, feeds, cleans, etc., the child will begin to expect this type of love and care. Bowlby further posits that these expectations will become internalized by the infant and organized into "working models" – concepts of how the physical world and the people in it will operate in relation to the child. Research by Mikulincer and Shaver, as reported by Ryan, Brown, and Creswell (2007) adds to this theory and provides evidence that "the priming of positive and loving attachment figures can activate positive states of mind, whereas the priming of rejecting, controlling or cold figures may activate fewer, and perhaps even crowd out, people's positive capacities" (p. 177).

Attachment styles. Research by Ainsworth, Blehar, Waters, and Wall (1978) investigated patterns of these significant parent-child relationships and found distinct relational styles based on the quality of infants' attachment; the types were categorized as

secure, anxious-ambivalent (or anxious-resistant), and avoidant. Later in the investigation of attachment theory, a fourth style, disorganized, was determined (Main & Solomon, 1990).

Secure attachment. A secure attachment style is the result of a mother's ability to appropriately attune to her infant's needs, as seen in Ainsworth's "infant strange situation" when children are observed to welcome their caretaker's return after a separation; secure children may display distress while separated, but seek proximity and find comfort in their caretaker once they return (Ainsworth, 1989). Security is not solely dependent on mothers' specific actions or behaviors, however. The accepted position of attachment theory suggests that security depends on children's "felt sense" of continuous love and safety (Ainsworth et al., 1978). Bowlby suggests that the "working models" of securely attached children support a belief that they are worthy of care and that others can be counted on for support when needed (Ainsworth, 1989). Research by Goldberg (1995) found that most (65%-75%) 1-year-olds in a U.S., cross-cultural sample displayed secure attachment. According to Bowlby's theory, this "felt security" forms a prototype for later relationships outside the family.

Anxious (anxious-ambivalent, anxious-resistant) attachment. According to attachment theory, when a "felt sense" of security is weak, infants display changes in physiological arousal that influences their behavior and internal working models (Fraley & Shaver, 1997). In an effort to achieve security, children may exhibit clingy behavior and hypervigilance about their caretaker's whereabouts. When these children are separated from their primary caretakers, they often display heightened distress; when the caretakers return, the infants typically show ambivalence (subtle anger) and an inability to be comforted (Ainsworth, 1989). Ainsworth (1989) labels this style of behavior as anxious-ambivalent attachment.

Bowlby (1973) claims that anxious attachment results when children receive consistent messages that a) their caretakers are generally not good at responding to their needs, and/or b) they, as children, are not worthy to be responded to in helpful ways. As such, Campbell and Marshall (2011) report, "Children with anxious-ambivalent attachments exhibit approach-avoidance behaviors toward their caregivers when distressed, mixing bids for comfort and support with withdrawal and strong expressions of anger" (p. 1221). Investigation into this theory reveals that anxious-ambivalent children tend to display hypervigilance in monitoring their mothers/caregivers and additionally perform attention-seeking behaviors to ensure that their attachment figures remain present. Furthermore, the energy directed toward the caregiver results in a lack of exploration in the child's environment, and puts the anxiously attached individual in a state of mind attuned to potential loss (Bowlby, 1969, 1973). An estimated 10%-15% of American infants can be characterized by this anxious, resistant attachment style (Goldberg, 1995). As a result, children faced with perceived caretaker ambiguity can develop substantial doubt about the behavior of other relationship figures later in life (Campbell & Marshall, 2011).

Avoidant (dismissive) attachment. The third style of attachment described by Ainsworth et al. (1978) is avoidant, or dismissive attachment. Infants and children in this category experience a lack of felt security, and rather than seek more from their caretakers, they learn to seek safety and soothing elsewhere (Heflin, 2015). Experts believe that childhood trauma, such as abuse or neglect, can activate this style of parent-child connection. Avoidance, then, can quickly become a defense strategy employed by the child as a way to reduce the possibility of experiencing addition pain and rejection (Foroughe & Muller, 2011). Additionally, Mikulincer and Shaver (2007) posit that individuals with the

avoidant attachment style may reject the idea that their caretakers have not met their needs, then project their internal pain on other relationships.

This system of denial and frustration fosters a belief that while they are deserving of care, others cannot be trusted and should therefore be avoided (Heflin, 2015). This dynamic can be observed in the "infant strange situation" when infants avoid proximity and interaction with their mothers/caregivers, and lack responsiveness when attachment figures return after separation (Ainsworth et al., 1978). According to Goldberg (1995), more infants display this avoidant pattern of behavior than the anxious style; research illustrates that roughly 20% of U.S. and Western European samples display avoidance attachment, and approximately 10% of cross-cultural samples exhibit the style. Therefore, the avoidant attachment style is a significant factor in society.

Disorganized attachment. Finally, and more recently, a fourth style of attachment has been identified by Main and Solomon (1990) in addition to secure, anxious-ambivalent, and avoidant styles, and that is "disorganized." This coding may be designated when infants and children present inconsistent behaviors in relation to their caregiver, which may be brief, out-of-context, unexpected, or anomalous. Researchers posit that this undifferentiated chaos suggests a child's disorientation, fear of the caregiver, and possibly high levels of conflict (confusion) about how to approach their caregiver (Duschinsky & Solomon, 2017). Wazana et al. (2015) report, "disorganization is defined as the collapse of attachment strategy under conditions of stress; under such conditions, disorganized individuals select a set of behaviors that are irrelevant to their need for downregulation of discomfort" (p. 1157). Additionally, it is estimated that less than 1% of infants in the U.S. cope with this style of attachment (Goldberg, 1995). Less is known about the environmental factors that give rise to disorganized attachment, but what is clear in this style, as well as in the others, is that children respond to attachment figures in ways that

promote physical and psychological safety, and patterns of such behaviors will act as templates for future relationships.

Attachment in Adults

The basic theory of attachment presented by Bowlby and added to by Ainsworth suggests that children's relationships with their primary caregivers builds a foundation for other important relationships, interactions, and perspectives throughout the lifespan. Research using the Adult Attachment Interview developed in the 1980's provides insight into how childhood attachment is represented in adult relations (Bartholomew & Horowitz, 1991). Interviews with young adults have helped illustrate how security and insecurity play out later in life. As Bowlby and Ainsworth predicted, evidence shows that securely attached adults tend to view themselves as relatively free of distress and claim others are supportive. However, insecurely attached individuals tend to grow up believing either they are flawed, or others are unsupportive. Bartholomew and Horowitz (1991) continue this explanation by stating that anxiously attached children develop into preoccupied adults who view themselves as distress prone even though others are viewed as supportive. Moreover, avoidant/dismissive children grow into adults who have faith and confidence in themselves, but hold less faith and confidence in others. Akbag and Imamoglu (2010) further address that without intervention or corrective experiences, insecurely attached children will reach adulthood and continue to demonstrate a negative view of themselves, others, or both.

Adult attachment styles. The findings from Bowlby, Ainsworth, and other researchers justify Bartholomew and Horowitz's model of adult attachment, which classifies adult patterns that align with infant attachment behaviors; in adults, the styles are referred to as secure, preoccupied (anxious-ambivalent), fearful-avoidant (a subcategory of avoidant), and dismissing (avoidant). Bartholomew and Horowitz did not classify adults

with disorganized attachment styles, but as the theory suggests, disorganized children will likely develop into disorganized adults and maintain a confused, conflicted, and inconsistent pattern of behavior in relation to other key people in their lives.

Prevalence and persistence. As expected, attachment styles tend to persist over time. Waters, Merrick, Tremboux, Crowell, and Albersheim (2000) conducted a 20-year longitudinal study on 50 participants and found that 72% of adults were found to have the same attachment classification that they did in infancy. While evidence suggests styles are mostly unchanging, theorists and researchers have explored how individuals can "earn" secure attachment over time, illustrating that insecurity in childhood may not have permanent results (Siegel & Hartzell, 2003). While Bowlby (1988) agrees that attachment is not entirely stable, he warns that adults can be negatively affected by adversity and old wounds can be re-opened at any time. Siegel and Hartzell (2003) further this notion and suggest that adult attachment insecurity will maintain if individuals do not have supportive relationships and a capacity toward self-understanding. Although attachment is malleable, studies of young adults have shown that adult attachment distributes across the secure and insecure styles similarly to those found in infants and children. Research by Hazan and Shaver (1987) and Mickelson, Kessler, and Shaver (1997) has found that about 55-65% of young adult samples display secure attachment stemming from infancy, while 15-20% demonstrated preoccupied/fearful (anxious/ambivalent) attachment, and 22-30% met characteristics of dismissing (avoidant) attachment.

In older adult populations, research indicates a different trend for each attachment style, such that fewer numbers of elderly individuals demonstrate preoccupied (anxious/ambivalent) attachment, and rates of dismissing (avoidant) attachment are higher than young adult samples. Magai and Cohen (1998) and Magai et al. (2001) report older adult attachment rates range widely from 22-56% in the secure category, 0-6% in the

preoccupied/fearful category, and 37-78% in the dismissing category. The decrease in preoccupied attachment from young adulthood to older adulthood may be a result of "earned security" that Siegel and Hazan illuminated. Moreover, the increase in dismissive attachment may be an effect of a greater number of losses experienced by older populations (Diehl, Elnick, Bourbeau, & Labouvie-Vief, 1998) or cohort differences in the samples used in the older adulthood studies (Magai et al., 2001). Longitudinal studies on attachment styles from young adulthood to older adulthood have not been conducted, therefore one cannot conclude that adult development directly impacts attachment styles, but research does indicate demographic differences.

Effects of Attachment Styles

There is no shortage of research that addresses how secure attachment is generally related to positive emotions or outcomes for both children and adults. Similarly, evidence is clear that insecure attachment is linked to negative emotions and adverse symptoms and behaviors throughout the lifespan (Bartholomew & Horowitz, 1991; Fraley & Shaver, 1997; Martins, Canavarro, & Moreira, 2016). Mikulincer and Shaver (2007) point out that secure attachment based on loving and attuned parenting primes individuals for positive states of mind throughout development, whereas insecure attachment via rejecting, controlling, or emotionally cold parenting styles primes individuals for fewer positive capacities. Adults with secure attachment maintain balanced, consistent, and objective views of themselves and of their relationships, even when events are not favorable (Foroughe & Muller, 2012). Bowlby (1988) reports that as securely attached children age, they maintain cheerful and even popular dispositions, however, insecurely attached individuals seem to convey a sense of unhappiness and alienation.

Rooted in social mentality theory, a self-compassion model by Gilbert, Hughes, and Dryden (1989) advances that self-compassion is made possible by the care an infant

receives from their primary caretaker. The authors note that a consistent and compassionate environment in early childhood primes individuals with the ability to respond to themselves in a compassionate matter later in life. This concept is in line with Bowlby's (1969) attachment theory and adds that shame is constructed from a lack of self-compassion. Bowlby (1980) also indicates that when a person experiences compassion as an adult but perceived a lack of such affection as a child, that person may be reminded of negative feelings that promote a shame response, and therefore they may reject compassion; they may reject the concept of self-compassion for similar reasons.

Specific adverse effects can be found among insecurely attached adults, beyond negative self-appraisals. Research findings, described below, illustrate how insecure attachment can prime adults for problems with emotion regulation, interpersonal conflicts, and behavioral concerns.

Emotional dysregulation. Epstein (1980) describes the emotional vulnerability of insecurely attached adults clearly by writing, "people with low self-esteem carry within them a disapproving parent who is harshly critical of their failures, and registers only short-living pleasure when they succeed. Such people are apt to be unduly sensitive to failure and rejection, to have low tolerance for frustration, to take a long time to recover following disappointments, and to have a pessimistic view of life" (p. 106). This conceptual understanding has inspired social scientists to explore the relationship between attachment insecurity and emotional dysregulation.

Research on attachment theory provides evidence that individuals with anxious/ambivalent or avoidant attachment styles have increased risk for psychological distress. Wei, Shaffer, Young, and Zakalik (2005) summarize several studies that demonstrate the correlation between insecure attachment and effects like depression, anxiety, and negative affect, as well as anger, shame, and pathological narcissism. A four-

year longitudinal study by Davila and Bradbury (2001) assessed the attachment styles of 172 married couples, and found that individuals with insecure (anxious or avoidant) attachment styles had higher levels of neuroticism, low self-esteem, and depression. In additional literature, studies have shown that insecurely attached individuals report lower levels of trust and more frequent negative emotions compared to their securely attached peers (Lopez et al, 1997).

Along with these examples of emotional dysregulation, evidence suggests that grief and bereavement are also particularly affected by insecure attachment. Schenck, Eberle, and Rings (2016) allege that complicated grief can arise when anxious/ambivalent or avoidant individuals become preoccupied by the death of a loved one, which is associated with protest or persistent longing for resumed proximity to the deceased. Mancini and Bonanno (2012) researched how insecure attachment patterns impact asymptomatic grievers as well as complicated grievers. They concluded that anxious and avoidant attachment is associated with continued reliance on attachment figures post-mortem, and this insecurity contributes to complicated, enduring bereavement, inflexibility to an altered interpersonal world, and difficulty developing new attachment relationships (Mancini & Bonanno, 2012).

Interpersonal effects. In addition to ongoing emotional distress, literature explains that in adult relationships, romantic partners can symbolically take the place of primary caregivers, and attachment issues from childhood resurface. As compared to securely attached adult, insecurely attached adults face interpersonal concerns in romantic relationships and with peers. While people with secure adult attachment demonstrate greater relationship satisfaction and report happier and more trusting experiences, those with attachment anxiety display clingy and dependent behavior in relationships, which illustrate their sensitivity to rejection and abandonment. Moreover, individuals with an

avoidant attachment style are characterized by discomfort with intimacy, which mirrors their distrust and desire for distance from their initial caregivers (Martins, Canavarro, & Moreira, 2016).

Feeney and Kirkpatrick (1996) conducted laboratory studies with preoccupied (anxious/ambivalent) adults and noted that subjects had higher levels of sympathetic nervous system activity when partners were separated compared to when they were joined. Fraley and Shaver (1997) further found that preoccupied participants reported higher levels of separation anxiety even in preparation for a real-life separation, as compared to securely attached adult participants. Meanwhile, Fraley and Shaver's research illustrates that adults with dismissing / avoidant attachment characteristics employ "behavioral strategies (such as avoiding close contact), emotional strategies (such as not allowing oneself to become emotionally attached), and cognitive strategies (such as directing attention away from stimuli that may activate the attachment system)" all as ways to cope with the threat of loss and rejection (p. 1090).

This evidence extends to peer interpersonal relationships as well. Research conducted by Saavedra, Chapman, and Rogge (2010), Davila, Karney, and Bradbury (1999), and Mikulincer and Shaver (2003) has illustrated that insecurely attached individuals have enduring vulnerabilities that, when triggered by ambiguous interpersonal interactions, can produce symptoms ranging from defensiveness and hostility, to hyper-vigilance and excessive proximity-seeking. Interpersonal conflicts are demonstrated between friends, family members, coworkers, and other groups as well as intimate partnerships. Finally, literature indicates that attachment quality among friends intensifies as children age into young adulthood. Friendships become increasingly significant, focusing on intimacy, loyalty, and commitment, and often mirror the security children felt

in their mother-child relationships (Dunn, 2004). All of this confirms that adults face an array of interpersonal challenges that reflect their attachment styles.

Behavioral health effects. Another domain of psychological health that is effected by insecure attachment in adulthood is behavioral. Frequently, researchers assess how problematic and destructive behaviors affect relationships (Simpson, Rholes, & Phillips, 1996; Collins & Feeney, 2000), but more is beginning to be understood about how attachment insecurity impacts health behaviors like substance use/misuse, sleep, and eating disorders, just to name a few. Cook (1991) examined how early childhood attachment positions individuals to experience either security or shame throughout the lifespan; he writes that a self-structure dominated by shame emotions makes individuals vulnerable to behaviors that try to ameliorate shame. Cook cites research that links insecure attachment to alcoholism, drug use, and bulimia via shame as a moderator.

Other habits like sleep have proven to be affected by attachment issues as well. Researchers in Canada hypothesized that people with preoccupied/anxious attachment insecurity, who display hypervigilance during the day, would further exhibit interrupted sleep quality at night. Indeed, they found a significant association between subjects' attachment anxiety and the proportion of their sleep spent in alpha waves, which illustrates light, unsound, anomalous sleep (Sloan, Maunder, Hunter, & Moldofsky, 2007).

Lastly, disordered eating can be a behavioral effect of insecure attachment in addition to substance use and sleep dysfunction. A study of 96 women with anorexia nervosa and bulimia nervosa found that preoccupied attachment was a significant predictor of body dissatisfaction, even after confounding effects like depressive symptoms and body mass index were controlled (Troisi et al., 2006). These findings are consistent with theorists who postulate on the damaging long-term effects of insecure attachment in adulthood.

Shame's Problematic Role in Attachment Disorders

A common thread between the psychological, interpersonal, and behavioral effects of insecure attachment in adulthood is shame. Bowlby (1988) understood shame's role in child development, and explained it as a natural, biological response when a child see's their caretaker as unavailable or hurtful. In such situations, a child may surmise they are bad and unworthy of being cared for appropriately, and they may internalize a deep and lasting message that they are flawed and unlovable. Likewise, if a child infers that their caretaker is bad for not meeting the child's needs, and the child still depends on the caretaker and longs for attunement, the child may reject anger toward the caretaker and experience shame instead. In this way, shame is adaptive and attempts to protect one's relationships and self from additional harm.

Shame has also been defined as an injury to the self as a result of contemptuous or humiliating treatment from a valued person (Erskine, 1994; Evans, 1994). Friel (2016) describes the function of shame and its implications on psychological processes, relationships, and behaviors, stating, "toxic shame is the internal experience of unexpected exposure causing us to hide from ourselves and others, believing the self to be defective" (p. 533). Furthermore, Brown (2012) claims that shame "is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging" (p. 69). This feeling and deprecating view of reality is what some experts see as the dominant emotion presented by adults in therapy (Dearing & Tangney, 2011). Although shame may be adaptive in the process of attachment as Bowlby conceptualized, it also serves as a conduit for psychological distress, dysfunctional interpersonal relations, and maladaptive health behaviors.

In addition, the experience of shame may depend on one's attachment style. Research stemming from Bowlby's attachment theory has validated the link between shame and all insecure attachment styles. Wei et al. (2005) assessed shame proneness in

an adult sample and found a positive correlation between shame and both attachment anxiety and avoidance. The study further illustrated that secure attachment was associated with decreased rates of shame. The authors noted that participants who reported low satisfaction of their basic psychological needs also had enhanced effects of shame, and this was highly correlated with participants' anxious or avoidant attachment insecurity. Additional research by Gross and Hansen (2000) corroborated the finding that secure adult attachment is negatively associated with shame proneness, while preoccupied and fearful-avoidant attachment styles are positively associated with shame proneness. Likewise, Lopez et al. (1997) assessed that shame was significantly correlated with attachment-related anxiety, and in addition, they found that because of shame, insecurely attached persons may have more difficulty in collaborative problem-solving. This is because insecure / anxiously attached individuals attribute inappropriate responsibility on themselves in stressful relationship events, and this interferes in their ability to execute reparative problem-solving efforts.

However, the Gross and Hansen (2000) study did not find an association between dismissing-avoidant attachment and shame proneness. Other research by Consedine and Magai (2003) adds to the anomaly of dismissing-avoidant attachment, suggesting that shame is hard to pin-point in adults with this style of attachment. Even so, the authors did discover a greater prevalence of shame in older adults with fearful-avoidant attachment. Fraley and Shaver (1997) studied dismissive attachment and noted that participants with this attachment style were able to acknowledge some negative effects due to a lack of family support, but they did not appear upset or demonstrate an internalization of their anger / attachment protests. Theorists propose that adults with dismissive-avoidant attachment styles exaggerate their independence and self-reliance as a way to unconsciously prevent and protect against painful feelings like shame (Dozier & Kobak,

1992; Fraley & Shaver, 1997). These findings, although contrasting those with fearful/anxious attachment, serve as a foundation of evidence for how shame contributes to adult attachment concerns.

Individuals with dismissive/avoidant attachment styles may demonstrate less shame than other insecure attachment styles, yet research points out that the avoidance of shame may be just as dysfunctional and painful as shame itself. Martins, Canavorro, and Moreia (2016) studied attachment styles and shame, and their results suggest that individuals with avoidant tendencies do possess internal shame, but more significantly, it is when they engage in avoidance behaviors to self-protect that high levels of external shame (negative views of significant others) are triggered. Theorists claim that shame, as a defense organization, "stems from fear of rejection and is used to maintain a consistent self-concept" (Martins, Canavorro, & Moreia, 2016). Therefore, shame appears to be at the core of both anxious and avoidant attachment. Rather than focusing on peripheral and perhaps more observable symptoms of insecure attachment styles (anxiety, depression, rage, withdrawal, etc.), counseling can target shame to dismantle the effects of insecure attachment.

Multicultural considerations regarding shame. Attachment theory was born from an evolutionary-ethological perspective (Ainsworth et al., 1978), which suggest that the process of attachment is similar in individuals across cultures. Interestingly, the experience of shame that plays a role in attachment disorders can vary depending on cultural norms. Investigative research illustrates that in collectivistic cultures like China, the Philippines, and Spain, individuals view shame as a moral, virtuous emotion that motivates them to rebuild connections with attachment figures and community members. In contrast, when individuals experience shame in individualistic societies like the Netherlands and the U.S., they withdraw and direct their energy inward as a means of

self-protection, which in turn, impacts their self-esteem (Bagozzi, Verbeke, & Gavino, 2003; Fischer, Manstead & Mosquera, 1999; Fung, 1999). This evidence suggests that insecure attachment and shame may have a more damaging impact on the psychological well-being of western and individualistic persons compared to other cultures due to the heavy investment in autonomy (Mesquita & Karasawa, 2004). Therefore, the experience of shame is not always crippling, and mental health implications may vary depending on the client's culture and felt sense of community.

In addition to the impact culture has on shame as it relates to attachment issues, gender is another important consideration. One study found that while the antecedents to shame may be different among men and women, both genders report similar levels of shame (Fischer, Manstead, & Mosquera, 1999). Similarly, Brown (2012) surveyed over 1,200 men and women to determine variances in shame and found that the genders are equally affected by shame, but the triggers may be different. Men experience shame related to perceived weakness, while women experience shame related to physical appearance and mothering ability.

An analysis of how men and women cope with shame found that both genders are significantly affected by shame, specifically in relation to self-esteem, but there were no significant differences between genders (Yelsma, Brown, & Elison, 2002). Furthermore, in a study by Gross and Hansen (2000), women reported higher levels of shame than men, which the authors noted was because women generally view interpersonal relationships as more important than men; when the researchers controlled for the mediating effects of interpersonal connectedness, the gender differences in shame responses dissolved. These findings illuminate that men and women may seem to experience shame differently, and that women may report feeling shame more than men. However, counseling professionals should keep in mind that while the antecedents to shame may vary depending on gender,

the outcome of shame is equally formidable for men and women. Shame proneness impacts the attachment security of men and women alike, therefore gender should not be a major factor in considering Eastern-based treatment options for attachment concerns.

CHAPTER 3

Review of Key Eastern Philosophy Principles and Therapeutic Practices

Non-Attachment / Non-self

While individualistic cultures like the United States generally find meaning and value in the concept of "self," mindfulness and self-compassion stem from collectivist cultures and Eastern philosophies that teach an alternative understanding of the word. Buddhist teachings describe the "self" in that each person has a self (lower case s), as well as a Self (capital S). The self refers to one's identity – thoughts and beliefs – that the brain uses as evidence for one's uniqueness; it includes one's answer to the question, "who are you?" (Eckhardt, 2010). In addition to this branch of consciousness, there is the Self, which Ram Dass (2013) explains is "the part of you that is aware of everything — just noticing, watching, not judging, just being present, being here now" (p. 34).

Buddhist philosophy provides an idea that striving to establishing a coherent sense of self, without utilizing the capital-s Self, is the very source of suffering (Siegel, 2014). This concept is not so very different from Freud's theory of the ego, id, and superego, or Jung's conceptualization of the animus, anima, shadow, and persona; even modern theories like the Internal Family Systems model recognizes that there are at least parts of the "self" that can feel sticky and cause people suffering (Siegel, 2014). Siegel (2014) further explains that constant mental chatter and thoughts that consist of "me," "my," and "I" perpetuate distress; he reports that ruminating thoughts help maintain a delusion that individuals are inherently separate, enduring beings. On the other hand, with practice in mindfulness and awareness of the egoic, lower-case self, one's individuated existence can be reframed to one of connectivity and constant flux. Siegel (2014) writes, "By repeatedly bringing our attention to sensory experience in the present moment, we see that what arises

in consciousness is a kaleidoscope of sensations and images, regularly narrated by subvocal words, which themselves arise and pass" (online).

Dass (2013) further explains the risks in spending all one's energy cultivating the "self." In his offering of Buddhist philosophy, Dass describes how people become attached to their identities and get stuck in vicious cycles of thought. Instead of using the term "Self," he describes simple awareness as "witness consciousness" (Dass, 2013). The ability to witness what's happening in the mind, just as one can be mindful of other sensations like the breath, sounds, colors, etc., allows you to get unstuck from ruminating thoughts; witness consciousness buoys you and keeps you from drowning in thoughts and emotions. Dass writes, "Once you understand that there is a place in you that is not attached, you can extricate yourself from attachments. Pretty much everything we notice in the universe is a reflection of our attachments" (p. 34). In other words, the more one focuses on the sense of self and identity, the more one will depend on it – even over-attach to it. However, mindfulness and self-awareness / witness consciousness provides a way for individuals detach from the painful experiences that circulate within the mind.

What Siegel, Dass, and others illustrate is what Buddhists, meditators, and those who heed Eastern philosophies have known for centuries: a peaceful state of mind comes from "being with" thoughts and emotions rather than identifying "as" the thoughts and emotions. Western psychology confirms there are psychological benefits when one exercises the approach of mindfulness and let's go of over-attachment to the self; such benefits include more satisfying interpersonal connections, less shame, decreased fear, and strengthened confidence (Siegel, 2014). By tapping into one's witness consciousness, not only will attachment to self-identity become less of a priority, but attachment concerns involving external objects and people will become less significant, and less painful as well. With benefits like this in mind, Western psychology has begun to examine different

concepts from Buddhist philosophy including mindfulness and compassion, which both play supporting roles in helping individuals practice getting unstuck from dysfunctional self-constructs.

Mindfulness

A hot topic in modern psychology is mindfulness. The mounting research and scholarly articles addressing the concept are beginning to pique the interests of Western clinicians and inspiring slow integration of mindfulness as a practical tool for mental health therapy. Mindfulness, however, is not a new concept, nor one born from the West. As described by Ludwig and Kabat-Zinn (2008), mindfulness is rooted in Buddhist practice and can be considered "a universal human capacity proposed to foster clear thinking and open-heartedness" (p. 1350). Others describe the term as a process used to gain attention of one's moment-by-moment experience (Bishop et al., 2004). Williamson (2003) explains mindfulness as a practice that provides a "continuing rediscovery of the self. It is a re-engagement with what gives life, with one's gifts and limits, with one's unique capacities and vulnerabilities" (p. 19).

With the growing interest in and incorporation of mindfulness in therapeutic contexts (and beyond), an operational definition was developed to bolster further research and practice with the technique. Bishop et al. (2004) clarify the broad definition of mindfulness as "a kind of nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is" (p. 232). The researchers elaborate, explaining that mindfulness is a mode or process – not a stationary mind-state – that allows one to self-regulate and sustain attention, switch back from nonawareness to awareness, and impede elaborative processing with curiosity, openness, and acceptance (Bishop et al., 2004). Based on this definition, experts postulate that the capacity for mindfulness is indeed universal and achievable.

With a better understanding of what mindfulness is, Western researchers have begun unearthing what makes this ancient Eastern technique so impactful in modern psychotherapy. Looking at its effectiveness in the therapeutic environment, Shapiro & Carlson (2009) point out several therapeutic strategies that incorporate mindfulness and help clients tease apart their thoughts from their identity. The authors write that with mindfulness, "clients learn to observe passing thoughts without assuming they are true or important and without having to act on their content… this frees the observer-self from being influenced by these passing mental events" (p. 56). Additionally, empirically supported benefits have been identified in those who practice mindfulness, including reduced rumination, stress reduction, boosts to working memory, focus, less emotional reactivity, more cognitive flexibility, and relationship satisfaction (Davis & Hayes, 2012). Mindfulness can also increase immune functioning among other physical health benefits (Davis & Hayes, 2012). Furthermore, mindfulness literature posits that acceptance, a key feature in both mindfulness and self-compassion, can reduce negative emotions like shame in clinical populations (Dunmore, Clark, & Ehlers, 1999; Goldsmith et al., 2014; Semb, Strõmsten, Sundbom, Fransson, & Henningsson, 2011). Mindfulness is a skill that can be developed by anyone or exercised via any number of therapeutic modalities. Overall empirical evidence supports that with practice, mindfulness can improve one's quality of life in the physical, emotional, cognitive, and spiritual domains.

Self-Compassion

Along with mindfulness, modern day researchers are returning to Buddhist roots and recognizing another strong link to psychological health, which is compassion. Buddhist philosophy furthers this concept and suggests love and compassion is not complete if it is not turned in toward the self. Psychologists are increasingly interested in the positive health benefits that come from self-compassion (Brach, 2003; Salzberg, 1997).

Investigation into the practice has found that self-compassion promotes soothing one's self from psychological suffering and allows increased self-understanding and self-care (Gilbert, 2009; Neff & Germer, 2013). In fact, other research suggests that self-compassion may be an underlying mechanism that bolsters mindfulness-based interventions (Kuyken et al., 2010). The practice of self-compassion as a treatment component is associated with what many social scientists, including MacBeth and Gumley (2012), call the "third wave" of cognitive behavioral therapies; in analysis of such treatment modalities, MacBeth and Gumley report empirical evidence that self-compassion aids in the development of wellbeing, reduces depression and anxiety, and increases resilience to stress.

Neff (2003) operationalized self-compassion so that its function could be better understood in terms of mental health. Her definition of self-compassion includes three parts: self-kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus over-identification when confronting painful self-relevant thoughts and emotions. Self-kindness may seem common sense, but Neff (2003) notes it is a critical aspect of mental health as it removes, or at least turns down the volume on the harsh inner-critic and allows one to hold a stressful internal problem with compassion rather than trying to control it. Additionally, a sense of common humanity is important in understanding self-compassion as it points out that the "self" is not a silo, and perceived failures and disappointments are experiences shared by all human kind (Neff & Germer, 2013). Neff's last factor in the self-compassion equation further involves letting go of personal narratives that promotes pain and suffering; this is done through a practice in mindfulness, which fosters an ability to step back from one's identity, thoughts, and anguishes so that self-worth isn't contingent on painful experiences (Neff, 2003).

A growing body of literature within the last decade illustrates the psychological benefits of self-compassion using Neff's Self Compassion Scale. The scale provides a 26-

item measure of oneself and the three components of self-compassion based on self-report. Neff and Germer (2013) reference several empirically validated strengths associated with self-compassion including emotional intelligence, ability to cope with stressors like academic failure, divorce, physical pain, and childhood maltreatment, and improved relationship functioning. Moreover, studies demonstrate that self-compassion can promote health behaviors including diet persistence, smoking reduction, seeking medical treatment when needed, and exercising (Neff & Germer, 2013). Further research by Hiraoka et al. (2015) and Kearney et al. (2013) provide evidence that increased self-compassion can lead to decreased symptom severity for those suffering from post-traumatic stress disorder. Nevine Sultan expanded on this finding, claiming that a main theme that clients who've experienced trauma bring to therapy is an inability to tolerate the present moment, and a somatic approach coupled with self-compassion training can support traumatized individuals (personal communicated presented at the American Counseling Association Conference, March 19, 2017). Finally, Neff and Germer (2013) conducted two studies, a pilot and a randomized controlled trial, and found that participants in both experiments who received training in mindful self-compassion reported greater life satisfaction as well as decreased anxiety, depression, stress, and avoidance. Given the evidence and breadth of psychological impact, self-compassion effectively bridges Eastern philosophy with Western science and adds volumes to the field of mental health.

Third-Wave Treatment Modalities

What is sometimes referred to as the first-wave in psychotherapy, behavioral interventions were initiated with Pavlov's classical and operant conditioning studies, and is now the fleshed-out theory of change. The second-wave incorporated cognitions and dysfunctional beliefs and attitudes into treatment; CBT remains a common and appreciated choice of therapy by practitioners and clients alike. The third-wave, in which this paper

focuses, extends client awareness beyond cognitions to all internal experiences, including physical sensations and emotions, and relies on mindfulness and compassion strategies to quell client defenses and avoidance efforts (Roemer, Williston, Eustis, & Orsillo, 2013). Buddhist philosophy has flourished in societies for thousands of years, yet its key principles have only recently been operationalized to assist in Western mental health treatments. With the knowledge that mindfulness and self-compassion can uniquely disarm shame and a range of other trans-diagnostic symptoms, a new wave of behavioral therapies has emerged that focuses on acceptance strategies (Hayes, 2004). Several treatment modalities have been born from this acceptance-based framework. A brief look at some of these approaches is advantageous before considering the overall effectiveness of mindfulness and compassion-based treatments on clients with shame and adult attachment concerns.

Compassionate Mind Training (CMT) and Compassion-Focused Therapy (CFT). CMT was designed by Gilbert and Procter (2006) as a group intervention targeting shame and self-criticism among patients with severe mood and personality disorders. A pilot study included 12 two-hour group therapy sessions that utilized specific activities to enhance clients' compassionate attributes and skills. Results indicated significant reduction in shame and self-criticism, as well as anxiety, depression Results indicated significant reduction in shame, self-criticism, anxiety, depression, and submissive interpersonal behavior, and demonstrated that CMT alleviated symptoms better than CBT treatment (Gilbert & Procter, 2006).

The findings from the CMT pilot study led to the development of Gilbert's (2009) compassion-focused therapy. CFT moves beyond training modules by integrating neurophysiological science with Buddhist psychology. Gilbert describes how this approach can influence client attitudes and behaviors, particularly shame responses, through

psychoeducation about the brain and one's emotional regulation system; this is offered in addition to the therapist modeling and instilling compassionate mind training, and helping the client develop feelings of safety, warmth, and connectedness (Gilbert, 2009). Replication studies, albeit with small sample sizes, have attested that CFT can bolster participant outcomes including increasing positive affect, hopefulness for the future, and a sense of self-compassion, along with decreasing experiences of shame (Boersma et al., 2015; Lawrence & Lee, 2014). Naturally, this evidence could be applied to individuals with insecure attachment as well, who experience a lack of safety and connectedness and enhanced feelings of shame.

Dialectical Behavior Therapy (DBT). Originally developed by Marsha Linehan to treat chronically suicidal individuals with borderline personality disorder, DBT has evolved to treat a variety of symptoms and maladaptive behaviors (Koerner & Dimeff, 2007). The authors write, "although DBT shares elements with the psychodynamic, client-centered, gestalt, paradoxical, and strategic approaches to therapy, it is the application of behavioral science, mindfulness, and dialectical philosophy that are its defining features (p. 2). Like CMT and CFT, DBT provides individual psychoeducation while bolstering clients' skills in emotion regulation and distress tolerance via acceptance and mindfulness (Koerner & Dimeff, 2007). Several studies have been conducted to assess the effectiveness of DBT within specific populations and subgroups. For adult, community-based clients with depression and Borderline Personality Disorder, DBT has shown significant reductions in self-inflicting injuries, psychiatric-related emergency room visits, and overall suicidality (Comtois, Holdcraft, Smith, & Simpson, 2007). Additional research has found that for participants with Borderline Personality Disorder, DBT effectively ameliorated experiential avoidance and expressed anger better than general therapy (Neacsiu, Lungu, Harned, Rizvi, & Linehan, 2014). These findings provide insight that DBT may also be

effective for other individuals who are known to avoid and withdraw, feel anger, and display emotional dysregulation, like those with anxious and/or dismissive attachment styles.

Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT). Jon Kabat-Zinn developed MBSR in 1979 with the intention of offering medical patients the benefits of meditation and mindfulness to alleviate stress, pain, and illness without the cultural, religious, and ideological factors associated with Buddhism (Kabat-Zinn, 2003). The eight-week group treatment model is designed as a complement to regular medical and psychological treatments and provides clients a framework for awareness, acceptance, and interconnectedness regarding their inner and outer experiences (Kabat-Zinn, 2003). Much like MBSR, MBCT was developed as an eight-week group therapy program with a focus on meditation and mindfulness strategies to relieve the symptoms of depression (Segal & Williams, 2001). The therapy aims to teach key skills, help clients become more aware of their bodily sensations, emotions, and cognitions, and help them mindfully accept then skillfully respond to their unpleasant, automatic thoughts and feelings. Interventions like MBSR and MBCT have bolstered client outcomes in emotional regulation and stress reduction (Cordon, Brown, & Gibson, 2009), which are particular vulnerabilities for those with insecure attachments (Ditzen et al., 2008 Gallo & Matthews, 2006; Hawkins, Howard, & Oyebode, 2007).

Mindful Self-Compassion (MSC). Based on Buddhist psychology, evidence on the benefits of both mindfulness and self-compassion, and related efforts, Neff and Germer (2012) developed a "hybrid" program for the general public as well as clinical populations. The MSC program was inspired by MBSR and MBCT and continues the trend of 2 ½ hour group therapy-style classes offered once a week, lasting eight weeks. Unique to MSC however, Neff and Germer's model teaches skills in loving-kindness and self-compassion,

and is considered to be a resource-building course that can overlay other therapies and mindfulness-based interventions. Assessments of MSC's effectiveness among community adults (mostly highly educated, middle-aged females with meditation experience) have found significant gains in participants' self-compassion, mindfulness, and well-being outcomes (Neff & Germer, 2012). This evidence helps build a case that self-compassion strategies can improve client outcomes, and research on its effectiveness with insecurely attached individuals would be a useful next step.

Acceptance and Commitment Therapy (ACT). Another branch of cognitive behavioral therapy based on emotional acceptance is ACT, developed by Hayes (2004). This model addresses not only behaviors and cognitions, but issues of spirituality, values, and the self, all while infusing mindfulness and compassion lessons into treatment plans. Hayes explains how ACT therapists pay attention to experiential avoidance and cognitive fusion so that clients can address barriers to their personal growth in the here and now. Cognitive-behavioral theories suggest that distortions in thoughts lead people to misperceive reality. ACT recognizes this and attempts to defuse cognitions from absolute truths, allowing clients to observe thoughts as they come and go and view the self as transcendent in order to develop psychological flexibility and resiliency (Harris, 2006). A study by Forman, Herbert, Moitra, Yeomans, and Geller (2007) found that ACT was equally effective as traditional cognitive therapy at improving depression, anxiety, functioning difficulties, and quality of life. However, in this study, participants who received ACT treatment showed less experiential avoidance, and increased ability to act with awareness (Forman et al., 2007). These findings may have implications for clients who exhibit avoidance, emotional distress, and unconscious interpersonal behaviors like those with insecure attachment.

Eastern Philosophy's Approach to Shame

In comparison to common Western approaches to mental health like those touched on in Chapter 1, Eastern philosophy addresses shame differently and perhaps more effectively. Rather than dull the experience of shame and trans-diagnostic symptoms with psychotropic medications, or by combatting the thoughts associated with shame as it may be in CBT, Eastern-based interventions use mindfulness and compassion to accept shame. Leary, Adams and Tate (2006) suggest that interventions grounded in Eastern philosophy like mindfulness and self-compassion focus clients on their immediate surroundings rather than abstract self-evaluative and self-conscious thoughts, which are internal processes that drive shame. Additional research confirms that guiding clients to mindfully experience their shame and practice self-soothing techniques like self-compassion can increase their tolerance of painful feelings without over-identifying with the emotion (Neff, 2003). Luoma, Kohlenberg, Hayes, and Fletcher (2012) describe how noticing and accepting shameful thoughts like "I am a loser" or "I am evil" can diffuse the cognitions from the emotional experience, and allow clients to work with their thoughts before taking overt action. Luoma et al. (2012) explored this approach with clients with substance use disorders and noted it helped the individuals "experience shame in a more open and mindful fashion, thereby allowing the emotion to perform its regulatory function" (p. 51). The study concluded that this mindful approach was effective in helping clients "step out of a cycle of avoidance and shame and move toward a path of successful recovery that leads to more stable reductions in shame and to more functional ways of living" (p. 51). This suggests that by bringing awareness to shame, clients can better address the underlying conditions of their psychological disorders and repair accordingly.

In addition to mindfulness, Eastern-based practices also emphasize compassion and self-compassion to treat shame. Compared to cognitive-focused strategies like CBT, where

clients can get stuck in justifying the logic of their self-criticisms, approaches that employ self-compassion allow clients to accept and sooth their shame (Lee, 2005; Gilbert & Procter, 2006). Gilbert and Procter (2006) explain that shame is a process involving self-directed hostility, contempt, and self-loathing along with an inability to generate feelings of self-directed warmth, soothing, and reassurance. Therefore, helping clients develop skill in self-compassion can uniquely address shame and bolster clinical treatment. The authors also address how shame is often an automatic reaction to threats, as seen in the attachment literature, so rather than trying to control it, a more helpful response to shame would be to have compassion toward the self and help clients provide their own corrective experiences to the threats they perceive.

In fact, an increasing number of studies show how therapeutic practices that incorporate Eastern-philosophical principles effectively ameliorate shame. Recent studies have illustrated that the more adept a person is at self-compassion, the less prone they are to feel shame (Woods & Proeve, 2014; Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011; Barnard & Curry, 2012). Knowing this, researchers have looked at how Eastern-based interventions, specifically, MBSR, DBT, and Mindful Self-Compassion, have led to significant decreases in shame-based trauma appraisals among clients in addition to significant reductions in emotional dysregulation issues like posttraumatic stress disorder and depression (Goldsmith et al, 2014; Harned, Korslund, Foa, & Linehan, 2012; Kearney et al., 2013). Furthermore, studies have come to recognize that Eastern modalities, especially self-compassion, can mitigate shame-proneness, which in turn predicts mental health variables like anxiety and depression (Van Dam et al., 2011; Roemer et al., 2013). These findings offer the benefits of mindfulness and self-compassion on independent variables like shame. It is logical, then, to assume that Eastern-based

treatments alleviate shame specifically in those with attachment disorders, but unfortunately research is yet to investigate this specific concomitant.

While there is a lack of scientific study on the relationship between third-wave modalities and shame in insecurely attached clients, a number of theorists advance that the antidote to shame – in individuals with or without secure attachments - may be compassion towards oneself (Brown, 2012; Tangney, Stuewig & Mashek, 2007). Brown (2012) furthers this solution by explaining how self-compassion builds resiliency against shame and its damaging effects. She writes, "when we are able to be gentle with ourselves in the midst of shame, we're more likely to reach out, connect, and experience empathy" (p. 75). This postulates that direct mindfulness and self-compassion interventions can assuage shame, which may have implications for adult attachment disorders as well.

Brown's conceptualization is supported by numerous experts and studies on shame and attachment (Bernstein, Tanay, & Vujanovic, 2011; Goldsmith et al., 2014; Martins, Canavarro, & Moreia, 2016; Lopez et al., 1997; Woods & Proeve, 2014), however, there are no known investigations that directly assess the relationship between attachment and how one copes with shame, or how specific Eastern-based interventions decrease shame in insecurely attached individuals. Given the rates of insecure attachment in adulthood and the known associations between insecure attachment and shame, it behooves social scientists to study exactly how third-wave modalities impact shame and reduce the negative effects of attachment disorders. There is clear evidence that treatments that incorporate mindfulness and self-compassion foster various mental health attributes and can reduce trans-diagnostic symptoms like shame, but how this would impact individuals with insecure attachment is unknown. Determining the utility of Eastern-based interventions on shame-prone clients with attachment concerns could have paramount implications for their emotional, interpersonal, and behavioral health.

CHAPTER 4

Conclusions: Eastern Therapeutic Approaches for Attachment Disorders

Many adults suffer from the lack of emotional and physical attunement they received as infants and children (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Mickelson, Kessler, & Shaver, 1997). Their anguish shows up in counseling offices as emotional dysregulation, interpersonal distress, and behavioral health problems. A central claim of this report is that shame often underlies these symptoms and syndromes. Anxiously-attached individuals may experience overt shame and internalized anger toward their caretakers that they spend enormous amounts of energy to conceal (Lopez et al., 1997). On the other hand, persons with dismissive-attachment styles may externalize their protests and display anger and avoidance in an effort to protect themselves from the unresolved pain of their vulnerable childhood experiences (Martins, Canavorro, & Moreia, 2016).

Shame is a universal emotion, yet one that is deeply painful and can act as a catalyst for trans-diagnostic symptoms for individuals with attachment insecurities (Friel, 2016). Experts in the field of psychology assert that shame is the dominant emotion that leads adults to therapy (Dearing & Tangney, 2011). Attachment researchers further posit that up to 44% of the U.S. adult population has an insecure attachment style based on their families of origin (Hazan & Shaver, 1987; Mickelson, Kessler, & Shaver, 1997). Because of a perceived lack of attunement from a one's primary caregiver in infancy and childhood, individuals can experience maladaptive shame that proliferates psychological distress (Davila & Bradbury, 2001). Symptoms and syndromes may include anxiety (Shaver & Mikulincer, 2002, 2007), depression (Feeney et al., 2003; Wei, Shaffer, Young & Zakalik 2005), complicated grief (Schenck, Eberle & Rings, 2016), substance use/misuse (Brady & Sonne, 1999; Cook, 1991), sleeping difficulties, (Hall et al., 2000; Sloan, Maunder,

Hunter & Moldofsky, 2007), and disordered eating (Troisi et al., 2006). In addition, interpersonal relationships are often affected by shame and insecure attachment, which range from familial conflicts, peer/friendship setbacks, and romantic challenges (Davila, Karney & Bradbury, 1999; Saavedra, Chapman, & Rogge, 2010). Clearly shame and insecure attachment can significantly impact client mental health.

Psychological symptoms that can accompany insecure attachment styles, like those mentioned above, are often treated in the West from a medical model perspective. That is, counseling professionals may focus treatment on the immediate symptoms a client discloses rather than the root of the issues. The ever-increasing rates of psychotropic medication use and demand for short-term, results driven therapies like CBT are examples of how Western culture influences individual mental health treatment (Kay, 2010). However, a new interest in ancient, Eastern philosophical practices provides a novel and more effective insight into psychological treatment. Therapeutic modalities that incorporate mindfulness and self-compassion can uniquely and effectively address shame and limit its pervasive impact on self-perspectives and relationships. Because evidence suggests that individuals with insecure attachment are especially prone to shame (Lopez et al., 1997; Martins, Canovorro, & Moreia, 2016; Wei et al., 2011), Eastern-based treatment may be particularly useful for such populations.

Therapeutic interventions grounded in Eastern philosophy offer insight into how individuals who are suffering can hold their psychological pain and shame with mindfulness and compassion rather than attempt to abolish it. Western psychology has just in the last 20-30 years begun to harness the power of Eastern perspectives by scientifically investigating mindfulness, self-compassion, and acceptance. As a result, a "third-wave" of psychological treatment has been introduced to enhance client outcomes where traditional behavioral and cognitive-behavioral approaches have fallen short. Modalities like

Compassion-Focused Therapy, Dialectical Behavior Therapy, Mindfulness-Based Stress Reduction, and Acceptance and Commitment Therapy teach clients to approach their problems with love and kindness instead of an urgency to change (Hayes, 2004).

These treatments can have a particular impact on shame. Researchers and practitioners suggest that third-wave interventions orient clients on the here and now, which steers them away from abstract self-evaluative and self-conscious thoughts associated with shame (Luoma et al, 2012). Studies have shown that mindfulness and compassion-focused interventions are positively correlated with many attributes of mental health and secure attachment, including emotional awareness, acceptance, and cognitive flexibility; similarly, a lack of mindfulness has shown to be linked with maladaptive mental health including thought suppression, rumination, impulsivity, and passivity (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Brown & Ryan, 2003). Moreover, self-compassion techniques can alleviate shame by promoting feelings of acceptance and resiliency (Neff, 2003). A therapeutic approach grounded in these concepts can be paramount for clients with insecure attachment who consciously or unconsciously pine for self-esteem, confidence, cognitive flexibility, overall mental health, and interpersonal acuity. These constructs naturally fit together but have not been studied as a whole. More research is required to better understand how shame can be quelled with mindfulness and self-compassion interventions for insecurely attached participants, but the established evidence suggests a clear, positive advantage.

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